STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WIN			10/25/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ALLIANCE DR		
WORTHI	NGTON HOUSE				', IN 46113		
					,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
R0000							
		r a State Residential	R00	000	Submission of this response a		
	Licensure Survey	y.			Plan of Correction is NOT a leg	-	
					admission that a deficiency ex	ISTS	
	Survey dates: O	ctober 22, 23, 24 & 25,			Deficiencies was correctly cite	Ч	
	2012				and is also NOT to be construct		
					as an admission against intere		
	Facility number:	003084			by the residence, or any		
					employees, agents, or other		
	Provider number				individuals who drafted or may		
	AIM number: N/A				discussed in the response or F	Plan	
					of Correction. In addition,		
	Survey team:				preparation and submission of		
	Marcy Smith RN	N TC			this Plan of Correction does Notice that the constitute an admission or	O1	
	Dinah Jones RN				agreement of any kind by the		
	Patti Allen BSW				facility of the truth of any facts		
					alleged or the correctness of a	ny	
	[October 22, 23 o	& 23, 2012]			conclusions set forth in this	,	
					allegation by the survey agend	y.	
	Census bed type:	:					
	Residential: 22						
	Total: 22						
	Census payor typ	oe:					
	Other: 22						
	Total: 22						
	10ta1. 22						
	Sample: 8						
	These State Resi	dential Findings are in					
	accordance with	410 IAC 16.2.					
	Ouality review c	ompleted 10/29/12					
	Cathy Emswiller	-					
	Camy Emswiller	IXIX					
	1				l .		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 1 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 10/2	E SURVEY PLETED 5/2012	
	PROVIDER OR SUPPLIEI NGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113				
WORTHI (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 2 of 21

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/25/2012
NAME OF P	ROVIDER OR SUPPLIER)	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	KOVIDEK OK SUPPLIER		10799	ALLIANCE DR	
WORTHI	NGTON HOUSE		CAMB	Y, IN 46113	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROWIDEDIG N. 431 OF GODE SOMES	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
R0055	410 IAC 16.2-5-1				
	Residents' Rights				
		ve the right to be treated as			
		onsideration and respect			
		Privacy shall be afforded for			
	at least the follow (1) Bathing.	virig.			
	(1) Balling. (2) Personal care	4			
		ninations and treatments.			
	(4) Visitations.				
		ervation, record review	R0055	Citation #1 R 055 410 IAC	12/15/2012
		the facility failed to		16.2-5-1.2(y) (1-4) Residents	
		ential information about		Rights - Deficiency What	
		discussed in a location		corrective action(s) will be	
		not be overheard by		accomplished for those	
		•		residents found to have be	en
	visitors and oth	iei residents. (affected by this deficient	
	Resident # 2)			practice? No other residents	
				were found to be affected.	-
	Findings includ	ie:		the facility will identify other	
				residents having the potento be affected by the same	uai
	The record of F	Resident #2 was		deficient practice and what	
	reviewed on 10	0/25/12 at 11:00 a.m.		corrective action will be take	
				The Residence Director revi	
	She was admit	tted to the facility on		community practices regardi	ng
	8/31/12 with th	e diagnosis of brain		disclosure of resident health	
		hospitalized 10/23/12		information and designated	
		eriorating condition. Her		area within the community for disclosure with appropriate)I
		ent and Negotiated		entities. The Residence Dire	ector
	Service Plan,"	•		re-educated staff as to our p	
	· ·	vas at a Level 1 and		and procedure regarding res	-
		rvices." A mini mental		confidentiality to ensure confidentiality	
				compliance. What measures	s will
		ompleted by a nurse,		be put into place or what	
		ndicated "Impairment."		systemic changes will the	
		exam dated 10/16/12,		facility make to ensure that	I
	indicated "Seve	ere impairment."		deficient practice does not recur? The staff were	
				recur? The starr were re-educated to the Indiana S	State
	On 10/24/12 at	t 11:20 a.m. an		To-educated to the indialia S	riaic

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 3 of 21

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/25/2012
NAME OF PROVIDER OR SUPPLY WORTHINGTON HOUS		10799	ADDRESS, CITY, STATE, ZIP CODE ALLIANCE DR Y, IN 46113	
PREFIX (EACH DEFI TAG REGULATOR	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
observation Residence Wellness D son sitting a lounge area From a dist feet (Library where the o place) the w and "discha From a dist feet (chair i words "I do eating in the " Level 1 to afford" were An activity w approximat where the o Residents # 21 were pa Resident #8 approximat a.m. During in in Residence 10/25/12 at was not "th conference	was made of the Marketing Director, the irector and Resident #2's at a table in the central a having a conversation. ance of approximately 45 y/TV Room to the table conference was taking words "hospice," "hospital," ance of approximately 15 in lounge to table) the bubt she'll ever be back to be dining room," "Hospice," Level 4," and "can't everheard. was taking place ely 18 feet from the table conference was being held. At 19, 13, 12, 1, 16, 22, and officipating in the activity. By walked by the table, ely 4 feet away, at 11:30 terview with the Marketing Director on 9:50 a.m. he indicated it is norm" to hold family is in the central lounge. He usually have conferences		ruling R 055 410 IAC 16.2-5-1.2(y) (1-4) Resident Rights and our policy and procedure regarding resident confidentiality. The Residence Director and/or Designee will responsible for ensuring resident care conferences are held in designated area within the community that preserves the resident's dignity and confidentiality pertaining to his her medical records and protected health care informa How the corrective action(s) will be monitored to ensure deficient practice will not rei i.e., what quality assurance program will be put into place? The Residence Direct and/or Designee will be responsible for monitoring resident confidentiality throug weekly rounds of the community to ensure continued complian with the above referenced regulation for a period of 6 months. Findings will be reviewed and corrected throu the Worthington House QA process. A Quality Assurance meeting will be held after six months to determine the need the ongoing monitoring plan. Findings suggestive of compliance result in cessation the monitoring plan will be ba upon results of random review that indicate no additional are of concern concerning the aba referenced regulatory criteria.	be be lent a sor tion. the cur, tor h nity ce d for n of n of seed vs as ove

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 4 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMI	E SURVEY PLETED 5/2012
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP (ALLIANCE DR	CODE	
WORTHII	NGTON HOUSE			′, IN 46113		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Regional Director of O Care Management and Designee will complete site visits of communit continued compliance date will the systemic be completed? 12/15.	Quality and door e Quarterly to ensure . By what c changes	DATE

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIC	00	COMPLETED
			A. BUILDING		10/25/2012
			B. WING		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				ALLIANCE DR	
WORTHII	NGTON HOUSE		CAMBY	′, IN 46113	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
R0120	410 IAC 16.2-5-1	<u> </u>	1110		
10120	Personnel - Nonc	()()			
		e an organized inservice			
	` '	ining program planned in			
		ersonnel in all departments			
	·	Training shall include, but			
		esidents' rights, prevention			
		ection, fire prevention,			
		prevention, the needs of			
		ations served, medication			
	administration, ar	nd nursing care, when			
	appropriate, as fo	ollows:			
	(1) The frequency	and content of inservice			
		ining programs shall be in			
		the skills and knowledge of			
		inel. For nursing personnel,			
		at least eight (8) hours of			
	•	endar year and four (4)			
		e per calendar year for			
	nonnursing perso				
	` '	the above required			
		staff who have contact with			
		ive a minimum of six (6)			
		a-specific training within six			
	· ·	ree (3) hours annually			
		t the needs or preferences,			
		vely impaired residents gain understanding of the			
		of care for residents with			
	dementia.	or care for residents with			
		ords shall be maintained			
	and shall indicate				
	(A) The time, date	_			
	(B) The name of t				
	(C) The title of the				
	(D) The names of				
		content of inservice.			
		Il acknowledge attendance			
	by written signatu				
	Based on record	review and interview the	R0120	Citation #2 R 120 410 IAC	12/15/2012
	facility failed to	provide the required 6	1	16.2-5-1.4(e) (1-3) Personnel	.
	inclining fulled to	provide me required o		Noncompliance What	
				• • • • • • • • • • • • • • • • • • • •	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 6 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	LDING	00	COMPLETED	
			A. BUII B. WIN			10/25/20	012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			ALLIANCE DR		
WODTHI	NGTON HOUSE				/, IN 46113		
WORTH	INGTON HOUSE			CAMBI	, 111 40113		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hours of dement	ia training within 6			corrective action(s) will be		
	months of hire a	nd 3 hours of required			accomplished for those		
		hereafter, for 4 of 5			residents found to have been	n	
		eviewed for dementia			affected by this deficient		
					practice? No residents were		
		al Service Assistant #6,			found to be affected. How the		
		, Dietary Services			facility will identify other		
	Coordinator and	Licensed Practical Nurse			residents having the potentia	aı	
	#8)				to be affected by the same		
					deficient practice and what corrective action will be take	2	
	Findings include	::			No other residents were found		
					be affected. What measures		
	The employee fi	le of PSA (Personal			be put into place or what	····	
		*			systemic changes will the		
		t) #6, hired 12/12/11,			facility make to ensure that t	he	
		of dementia training on			deficient practice does not		
	5/9/12 and 2 hor	urs of training on			recur? The Wellness Director		
	7/26/12.				and Residence Director were		
					re-educated to the Indiana Sta	ate	
	The employee fi	le of Housekeeper #7,			Ruling 410 IAC 16.2-5-1.4(e)(
		dicated she received 0			Personnel. The Wellness Dire	ctor	
	hours of dement				and/or Designee will be		
	nours of demend	ia training.			responsible for monitoring	_	
					employee in-service records to		
		le of the DSC (Dietary			ensure continued compliance the above referenced regulation		
	Services Coordin	nator), indicated she was			A spreadsheet will be created	J11.	
	hired 8/28/10 and	d had received 0 hours of			identifying each employee, the	eir	
	dementia trainin	g.			required training, and satisfact		
		<i>5</i>			of that training through schedu	uled	
	The employee f	le of LPN (Licensed			in-service education programs	s.	
	1 2	`			How will the corrective		
	· · · · · · · · · · · · · · · · · · ·	#8, hired 8/28/11,			action(s) will be monitored to	o	
	indicated she had	d received 1 hour of			ensure the deficient practice		
	dementia training	g on 8/9/12.			will not recur, i.e., what quali	-	
					assurance program will be p	ut	
	An interview wit	th Residence Director #2			into place? The Wellness		
		0:30 AM, indicted she			Director and/or Designee will		
		•			perform random monthly audit	ts of	
	had provided all	documentation available.			employee files to ensure		

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 7 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/25/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ALLIANCE DR	
WODTUI	NGTON HOUSE			ALLIANCE DR 7, IN 46113	
WORTH			CAIVID	1, 111 40113	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	She indicated sh	e was aware all		Alzheimer/Dementia trainings	
	employees are re	equired to receive 6 hours		completed in accordance with	
		ning within the first 6		Indiana state regulation 410 IA	VC
		and 3 hours of dementia		16.2-5-1.4(e)(1-3) Personnel.	
				Audits will be completed and reviewed for a period of 6 mor	athe
	training annually	y mercaner.		in order to determine the	iu io
				frequency of the ongoing	
	Two additional	· ·		monitoring plan. Findings	
	"Inservice Train	ing Attendance Log",		suggestive of compliance will	
	were provided b	y Residence Director #2		result in cessation of the	
	on 10/25/12 at 9	:40 AM verifying the		monitoring plan. Cessation of	the
	above findings.	<i>y</i> &		monitoring plan will be based	
	weev annumge.			upon results of random review	
				that indicate no additional area of concern concerning the abo	
				referenced regulatory criteria.	
				Regional Director of Quality ar	
				Care Management and/or	
				Designee will review the	
				employee training spreadshee	t
				monthly for 6 months then	
				quarterly thereafter to ensure	
				continued compliance. By wh	
				date will the systemic change	es
				be completed? 12/15/12	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/25/2012	
			B. WING		10/25/2012
	ROVIDER OR SUPPLIER		10799	ADDRESS, CITY, STATE, ZIP CODE ALLIANCE DR Y, IN 46113	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
R0154	(k) The facility shikitchen areas, concequipment, and unlitter and rubbish, repair in accordant Based on obsethe facility failed and kitchen appand prepare for maintained in a This had the porresidents who at the kitchen in the kitchen in the 22. Findings Include During the tour observation of on 10/22/12 at dietary staff #5 observed: 1) The stove her of greasy film godown in strandupper corner of burners where food was cooking.	afety Standards - Deficiency all keep all kitchens, mmon dining areas, tensils clean, free from and maintained in good nee with 410 IAC 7-24. Ervation and interview d to ensure the kitchen pliances used to store od were clean or a sanitary condition otential to affect 22 received meals from the facility population of the kitchen and noon meal preparation 10:50 a.m., with the following were	R0154	Citation #3 R 154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficient What corrective action(s) where accomplished for those residents found to have be affected by this deficient practice? No residents were found to be affected. The standard that the area behind the stove were cleaned. The refrigeration units were clear and thawed meat was placed a tray. Food items were covand dated per Indiana state regulation. The ceiling vents kitchen walls, kitchen corner cabinet droors, door frames, ceiling located in the kitchen cleaned and painted. The diffood storage area was also cleaned by staff. Items store the dry food area were placed less than six inches off the fitchen were cleaned and painted. How the facility with identify other residents have the potential to be affected the same deficient practice what corrective action will taken? The Residence Direct conducted rounds of the Residence to ensure compliants.	en e

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 9 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/25/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			ALLIANCE DR	
WORTHI	NGTON HOUSE			Y, IN 46113	
				1, 10110	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	3) The first Del	field refrigeration units		with R 154 410 IAC 16.2-5-1.5	
	had a large ket	tle uncovered not		Sanitation and Safety Standar	
	dated with a ha	ard grease film covering		No residents were found to be affected. What measures will	
	the substance i	inside the kettle sitting		put into place or what system	
		lf. The bottom shelf		changes will the facility make	
	had meat thaw			to ensure that the deficient	
		ry substance, the meat		practice does not recur? The	,
		-		Residence Director and dietar	
		on the shelf. The		staff were re-educated to our	
		d accumulation of dry		policy and procedure regardin	g
		os on the bottom shelf.		kitchen sanitation and safety	
	The third unit o	n the fist shelf on the		guidelines via our Registered	
	back of the unit	t was a large area of a		Dietician through consultation	
	smeared red su	ubstance.		and/or webinar. The Residence	e
				Director and-staff were	and
	Interview with o	lietary staff # 5		re-educated to kitchen safety a sanitation practices regarding	anu
		frigeration observation,		donning of hairnets when ente	erina
	_	ne meat should have		food prep areas. The cleaning	
				schedule for dietary staff and	
	•	nd the kettle should		maintenance have been upda	ted
		ered, dated, and		to ensure kitchen areas are cle	
	labeled.			and maintained in a state of go	
				repair. The Residence Directo	or
	,	our ceiling vents		and/or Designee will be	
	located betwee	n the stove and the		responsible for ensuring compliance with R154 410 IA0	
	food prep table	covered with a heavy		16.2-5-5.1(k) Sanitation and	
	accumulation o	of greasy film, dirt, and		Safety Standards. How will th	e
		own and extending to		corrective action(s) will be	
		ere was two more		monitored to ensure the	
	_	cated between the		deficient practice will not rec	eur,
	_			i.e., what quality assurance	
	•	nent sink, dishwasher		program will be put into plac	
		in dishes were stored		The Residence Director and/o	
		heavy accumulation of		Designee will perform random	
		, and dust hanging		weekly audits of kitchen	
	down and exter	nding to the ceiling.		sanitation using the Kitchen	
	5) In the dry foo	od storage there was		Sanitation Checklist to ensure continued compliance for a pe	
	, , , , , , , , , , , , , , , , , , ,	r near the flour bin.		of six months. Findings will be	
	1			or six months. Findings will be	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 10 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		10/25/2012	
		l		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t		ALLIANCE DR		
WORTHI	NGTON HOUSE			7, IN 46113		
				.,		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	On the floor in	the flour was individual		reviewed through the Worthing	gton	
	packets of crac	ckers and 1/4 bag of		House QA process after 6 six	<i>t</i>	
	pasta, couple o	of potatoes under the		months to determine the need an ongoing monitoring plan.	TOF	
	shelf.	•		Findings suggestive of		
				compliance will result in cessa	ition	
	6) There was a	built up of dirt and		of the monitoring plan. Cessa		
	,	e walls and corners		of the monitoring plan will be		
				based upon results of random		
		kitchen. Five of five		reviews that indicate no addition		
		cated in the kitchen		areas of concern concerning t	he	
		d had a built up dirt		above referenced regulatory		
	dust			criteria. The Regional Director Quality and Care Managemen		
				and/or Designee will complete		
	7) During meal	prep and service CNA		Quarterly site visits of commun		
	# 4 came in an	d out kitchen, in food		to ensure continued compliance		
	prep area with	out hair cover.		By what date will the system		
	p. op 2 22			changes be completed?		
	On 10/25/12 at	: 11:05 a.m. during		12/15/12		
		•				
		p interview with Dietary				
	_	ndicated everyone				
	_	chen should have hair				
	covering. She	indicated at this time				
	this had the po	tential to affect 22				
	residents who	received meals from				
	the facility kitch	nen.				
	ĺ					

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 11 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/25/2012	
	PROVIDER OR SUPPLIER		.	10799 A	ALLIANCE DR 7, IN 46113	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0214	each resident sha admission and sh semiannually and change in the resident A licensed nurse needs of the residenceds of the residenceds of the residenceds of the residenceds of the residenced interview, the far a prospective reprior to his admission facility policy, for reviewed for prevaluations in a (Resident #24) Findings include The record of Freviewed on 10 Diagnoses for I but were not limited blood president was designed to adultswho, doint impairment or residenced in the record of Freviewed on 10 Diagnoses for I but were not limited blood presidenced in the Region Operations on a.m., dated 07/1Resident Critical was designed to adultswho, doint impairment or residenced in the resident of the resident Critical Resident Critic	of the individual needs of all be initiated prior to all be updated at least upon a known substantial ident's condition, or more ent's or facility's request. Is shall evaluate the nursing lent. If the review and acility failed to ensure esident was evaluated hission, according to or 1 of 7 residents eadmission a sample of 8. Resident #24 was 1/22/12 at 1:30 p.m. Resident #24 included, nited to, dementia and soure.	R02	214	Citation #4 R 214 410 IAC 16.2-5-2(a) Evaluation - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #24 no longer resides at Worthington House. How the facility will identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take The Wellness Director and/or Designee conducted a review current residents and recent admissions to Worthington Ho to ensure compliance with the above referenced citation. No other residents were found to affected. What measures will put into place or what system changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Welln Director were re-educated to o policy and procedure regardin pre-admission evaluations for potential new residents. The	al of ouse be nic e ess our	12/15/2012

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
						10/25/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
WODT	NOTONILIOUS				ALLIANCE DR		
WORTH	NGTON HOUSE			CAMBY	′, IN 46113		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	During an inter Director and the Consultant on they indicated facility or home appointment for prospective redo an evaluation. They indicated always assess resident's mob and to do a minum description of Operations of Operations independent of the policy of the consultation inclusives an elopement of indicated any explusive and indicated any explusive over "4 Regional Nurse approval. The this time indicated approval.	rview with the Wellness le Regional Nurse 10/23/12 at 1:40 p.m., they "typically" go to a e or make an or the family to bring a sident into the facility to on prior to admission. It was facility policy to a prospective illity, elopement risk ni-mental exam. rview with the Regional erations and the ctor on 10/24/12 at 2:10 onal Director of licated it is "company ys do face to face or to admission. The		TAG	Wellness Director and/or Designee will be responsible of ensuring that pre-admission assessments are accurate and to date per our policy and procedure. How will the corrective action(s) will be monitored to ensure the deficient practice will not redice, what quality assurance program will be put into place. The Wellness Director and/or Residence Director will audit pre-admission evaluations for completion and accuracy per opolicy and procedure. The Regional Director of Quality C Management will perform rand monthly audits of pre-admission evaluations to ensure continuate compliance for a period of 6 months. Findings will be reviet through the Worthington House QA process after 6 six months determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessar of the monitoring plan will be based upon results of random reviews that indicate no additionareas of concern concerning the above referenced regulatory criteria. The Regional Director Quality and Care Management and/or Designee will complete Quarterly site visits of community ensure continued compliance. By what date will the system	cur, ee? our are dom on ed wed se to ation conal he of at en ity ce.	DATE
	facility on 10/1				changes be completed?		
	racinty off 10/1	/ I C.			12/15/12		

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 13 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIJII DING	00	COMPLETED	
			A. BUILDING B. WING		10/25/2012
		<u> </u>	B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ALLIANCE DR	
WODTHI	NGTON HOUSE			Y, IN 46113	
WORTH	NGTON HOUSE		CAIVID	1, 111 40113	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	A "Service Ass	sessment/Negotiated			
	Service Plan,"	dated 9/27/12,			
	indicated Resi	dent #24 needed the			
	facility to admi	nister his medications			
	_	ssistance with eating.			
		s were identified. This			
		sment/Negotiated			
		id not indicate who			
		assessment or how the			
	information was obtained, i.e. from				
		e resident or family			
	member.				
	During an inter	rview with the Regional			
	Director of Ope	erations and the			
	Wellness Direc	ctor on 10/24/12 at 2:10			
	p.m., the Wellr	ness Director indicated			
		Marketing Director had			
		ent #24 was not			
		face to face evaluation			
		esident's daughter			
		dicated he had done			
		e-admission Service			
		egotiated Service Plan			
	•	none with the resident's			
	_	Regional Director of			
	Operations and	d the Wellness Director			
	indicated the n	nini-mental exam and			
	the elopement	risk had not been done			
	•	esident had been			
	admitted to the				
	Δ Folstein Min	i Mental Status			
		dated 10/1/12 after			

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	e survey Pleted 5/2012
NAME OF PROVIDER OR SUPPLIER WORTHINGTON HOUSE			10799 /	ADDRESS, CITY, STATE, ZIP (ALLIANCE DR /, IN 46113	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAU	Resident #24 h facility and was score of "1" ou indicated a sco severe deficit." performed the An "Elopement signed by the N dated 10/1/12 a rrived at the fa admitted, indic indicated a sco High risk for ele R [egional] N[urs (Vice Presiden notification req After Resident facility on 10/1 indicated the fo 10/1/12 1930 " unsteadytries helpsaw resident fallen" 10/2/12 at 190 [without] assist reminding resident [with] timesvery un 10/3/12 1345 "0	ad arrived at the sadmitted, indicated a tof a possible 30. It ore of "10 or less It did not indicate who examination." A Risk Assessment," Wellness Director, after Resident #24 had acility and was cated a score of "48." It ore of "40 and above opement. Tector] O[perations], R ee] C[onsultant] and VP to of Clinical Services uired." #24's admission to the 12, nurses' notes ollowing: Wery confused and as to ambulate [without] dent in courtyard & had 0 "cont[inues] to get up cance staff constantly dent & to try & keep someone at all				DATE
	1unsteady" 10/6 8:00 a.m	. "fall at				

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	00	COMPLETED
			B. WING		10/25/2012
		l .		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER	L Company of the Comp		ALLIANCE DR	
WORTHI	NGTON HOUSE			', IN 46113	
				,	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	approx[imately] 1115 pEMS			
	(emergency me	edical service) here to			
	assessremai	ns in residence"			
	10/7/12 7:50 a	.m. "entered residents			
	room @ approx	x[imately] 1020 pm on			
		lent laying in fetal			
		ft] sideblood on bed			
		case & unresponsive.			
	-	nsported to [name of			
		e with POA [power of			
					
	, , , , , , , , , , , , , , , , , , ,	mass was identified			
	on cerebellum.	"			
	_	view with the Regional			
	•	erations and the			
	Wellness Direct	tor on 10/24/12 at 2:10			
	p.m. they indic	ated a face to face			
	preadmission e	evaluation, mini mental			
	exam and elop	ement risk should have			
	-	Resident #24 prior to			
		to the facility on			
		indicated if the			
	,	d been done face to			
	•	to 10/1/12, the facility			
	_	ermined they were not			
	able to meet R	esident #24's needs.			

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 16 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 10/25/2012		
			B. WIN			10/25/	2012
NAME OF PROVIDER OR SUPPLIER WORTHINGTON HOUSE				10799 A	ADDRESS, CITY, STATE, ZIP CODE ALLIANCE DR 7, IN 46113		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0273	(f) All food prepar (excluding areas maintained in accollocal sanitation ar standards, including assed on recording and interview, the ensure food was in a sanitary may observations. To affect 22 of the tresiding in the first food in the first food in the following as observed in a sanitary may observations. To affect 22 of the tresiding in the first food in the following food in the food food in the following food in the food food food food food food food foo	nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and ind safe food handling ing 410 IAC 7-24. The review, observation the facility failed to its prepared and served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential the 22 residents facility. The review of staff the facility dining its prepared in a served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential in a served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential in a served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential in a served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential in a served anner for 1 of 2 kitchen ind 3 of 3 dining room. This had the potential in a served picking up ind a served picking up in the roll. The room of the roll inding the served picking up in the roll inding Resident #3's with her bare hand in a served picking up inding Resident #3's with her bare hand in the roll inding Resident #3's with her bare hand in the roll i	R02	273	Citation #5 R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency What corrective action(s) will be accomplishe for those residents found to have been affected by this deficient practice? No reside were found to be affected. However found to be affected. However found to be affected by the same deficient practice and what corrective action will be take. The Residence Director conducted rounds of the Residence to ensure compliant with R 154 410 IAC 16.2-5-1.5 Sanitation and Safety Standar. No residents were found to be affected. No other residents we found to be affected. What measures will be put into plator what systemic changes withe facility make to ensure the deficient practice does not recur? The Residence Director and dietary staff were re-educated to our policy and procedure regarding kitchen sanitation and safety guideline via our Registered Dietician through consultation and/or webinar. The Dining Services	nts w al n? ace 5 (k) ds. ere ill act ot	12/15/2012

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		COMPLETED	
			B. WING		10/25/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			ALLIANCE DR		
WODTHI	NGTON HOUSE			7, IN 46113		
WORTH	NGTON TIOUSE		CAIVID		_	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	A facility policy	dated 6/2008, titled		Coordinator and/or Designee		
	"Safe Food Ha	ndling: Reasons and		be responsible for ensuring the	at	
		ived from Resident		food preparation and serving		
	· ·	10/24/12 at 10:20 a.m.		areas are maintained in		
				accordance with state and loc		
		1During meal service		sanitation and safe food handlest standards to ensure compliance	•	
		must be handled with		with R237 410 IAC 16.2-5-5.1		
	utensils or glov	ed hands"		Food and Nutritional Services	` '	
				How will the corrective		
	2) During an ob	oservation of meal		action(s) will be monitored to	,	
	preparation in t	the kitchen on 10/22/12		ensure the deficient practice		
		dietary staff #5 handled		will not recur, i.e., what quali		
		gloved hand that she		assurance program will be p	-	
		e refrigerator, cabinets,		into place? The Residence		
	•	•		Director and/or Designee will		
		ith out changing her		perform random daily audits o	f	
	gloves or wash	ing her hands.		food preparation and serving		
				during meals to ensure continu	ued	
	On 10/25/12 at	: 11:05 a.m. during		compliance for a period of 6		
	noon meal prep	o interview with Dietary		months. Findings will be		
	Manager she ir	ndicated the dietary		reviewed through our		
	_	ve changed gloves and		Worthington House QA proces after 6 months to determine the		
		nds and used tongs.		need for an ongoing monitorin		
	washed hel ha	nus and used tongs.		plan. Findings suggestive of	9	
				compliance will result in cessa	ition	
				of the monitoring plan. Cessat		
				of the monitoring plan will be		
				based upon results of random		
				reviews that indicate no addition		
				areas of concern concerning t	he	
				above referenced regulatory	,	
				criteria. The Regional Director		
				Quality and Care Managemen		
				and/or Designee will complete Quarterly site visits of community		
				to ensure continued compliance	-	
				By what date will the system		
				changes be completed?		
				12/15/12		
				<u> </u>	I	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 18 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER WORTHINGTON HOUSE (WA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LNC (IDENTIFYING INFORMATION) R0349 410 LAC 18,2-5-8,1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility designated with that resident administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		E SURVEY			
NAME OF PROVIDER OR SUPPLIER WORTHINGTON HOUSE INTEREST ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113 CAMBY, IN 46113 IN PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR ALLIANCE TA	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	COMPLE		ETED		
NAME OF PROVIDER OR SUPPLIER WORTHINGTON HOUSE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG RO349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Diagnoses for Resident #1 included, but were not limited to, diabetes Tree GUATORY OR ALLIANCE DR CAMBY, IN 46113 Diagnoses for Resident #1 included, but were not limited to, diabetes CAMBY, IN 46113 Diagnoses for Resident #1 included, but were not limited to, diabetes The record of Resident #1 included, but were not limited to, diabetes The record increase of Deficiencies The record of Resident #1 included, but were not limited to, diabetes The record of Resident #1 included, but were not limited to, diabetes							10/25/	2012
WORTHINGTON HOUSE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) R0349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes 10799 ALLIANCE DR CAMBY, IN 46113 PREFIX TAG PRACTOR TRANSFERDER PRACTOR TRANSFERDER PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG				B. WIN		ADDRESS OVEN STATE JID CODE		
CAMBY, IN 46113 CAMBY, IN 46113	NAME OF P	ROVIDER OR SUPPLIER	_					
CX4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG PREFIX TAG PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG COMPLETION DATE								
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) RO349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes COMPLETION TAG PREFIX TA	WORTHI	NGTON HOUSE			CAMBY	′, IN 46113		
RESPIX CACH DEFICIENCY MIST BE PRECEDED BY FULL TAG	(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWDEN'S NAME OF CORRECTION		(X5)
RO349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Diagnoses for Resident #1 included, but were not limited to, diabetes To clinical Records - Noncompliance What corrective action will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records of residents are reviewed of residents receiving insulin to ensure active well the records of residents receiving insulin to ensure active well the records of residents receiving insulin to ensure	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records of residents are reviewed of residents receiving insulin to ensure active well the records of residents receiving insulin to ensure active well the records of residents receiving insulin to ensure	R0349	410 IAC 16 2-5-8	1(a)(1-4)					
(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The received must maintain elimical records must be maintained with that responsibility. The records must be maintained with that responsibility. The records must be maintained with that responsibility. The records must be as follows: R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records-Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure	1100.10		` ,` ,					
on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records must be an employee of the facility and maintained with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective atcomedy at a corrective atcomedy and initiative action (s) will be accomplished for those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure			•					
maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records of the facility designated with that responsibility. The records must be as follows: R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records-Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration no the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure								
employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records must be as follows: R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure								
responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Piagnoses for Resident #1 included, but were not limited to, diabetes The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records. Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration nethe Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure			•					
follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes R0349 Citation #6 R 349 410 IAC 12/15/2012 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration en the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure								
(2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Piagnoses for Resident #1 included, but were not limited to, diabetes R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		•						
(3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		(1) Complete.						
(4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		(2) Accurately do	cumented.					
Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes R0349 Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		(3) Readily acces	sible.					
interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes in a manner was done in a manner and manner corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		(4) Systematically	organized.					
documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		interview, the facility failed to ensure		R03	49	Citation #6 R 349 410 IAC		12/15/2012
documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure						16.2-5-8.1(a)(1-4) Clinical		
administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure							nat	
which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes accomplished for those residents found to have been affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure						_		
which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes residents found to have been affected by this deficient practice? Staff will document Resident #1 included, affected by this deficient practice? Staff will document Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure								
complete documentation in clinical records in a sample of 8. (Resident #1) #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes The records in a sample of 8. (Resident #1 Resident #1's insulin administration on the Medication Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure			•			-	1	
complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes practice? Staff will document Resident #1's insulin administration on the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		for 1 of 7 record	ds reviewed for			affected by this deficient		
records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Resident #1's insulin administration on the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		complete docui	mentation in clinical			_		
#1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes administration on the Medication Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure						ļ ·		
Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Administration Record upon administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure			(. 100.00.11			administration on the Medicati	on	
Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		#1 <i>)</i>				Administration Record upon		
The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes Will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		Cindings includ				administration. How the facilit	:y	
The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		Findings includ	e.			will identify other residents	-	
The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes affected by the same deficient practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure						having the potential to be		
reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes practice and what corrective action will be taken? The Wellness Director conducted a review of the records of residents receiving insulin to ensure		The record of F	Resident #1 was				nt	
Diagnoses for Resident #1 included, but were not limited to, diabetes Wellness Director conducted a review of the records of residents receiving insulin to ensure		reviewed on 10	0/23/12 at 10:00 a.m.			-		
but were not limited to, diabetes review of the records of residents receiving insulin to ensure						action will be taken? The		
but were not limited to, diabetes receiving insulin to ensure		Diagnoses for I	Pesident #1 included			Wellness Director conducted a	1	
receiving insulin to ensure		•				review of the records of reside	nts	
1 mag = 11 min = 1		•				receiving insulin to ensure		
mellitus. appropriate documentation of		mellitus.				appropriate documentation of		
insulin administration is						insulin administration is		
A recapitulated physician's order for documented upon the Medication		A recapitulated	physician's order for			•		
October, 2012, with an original date Administration Record. No other		•	• •				er	
of 6/20/11, indicated Resident #1 was			<u> </u>			residents were found to be		
to have a sough a lie (a financiation		•					l	
to have accuchecks (a finger stick be put into place or what						· · ·		
blood test to measure blood sugar) systemic changes will the			G ,					
done 3 times per day. facility make to ensure that the		done 3 times p	er day.			facility make to ensure that t	he	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DUHLDING 00			COMPLETED		
			A. BUILDING 10/25/2012				2012
			B. WIN		PDDEGG CUTY CTATE (ID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
MODELII					ALLIANCE DR		
WORTH	NGTON HOUSE			CAMBY	′, IN 46113		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					deficient practice does not		
	Δ recanitulated	d physician's order for			recur? The Wellness Director		
	•				and Licensed Nursing staff we	re	
		, with an original date			re-educated to our policy and		
		licated Resident #1			procedure regarding		
	was to receive	Novolog insulin			administration of subcutaneou	s	
	injections per a	a sliding scale			insulin administration. The		
		the results of the above			Wellness Director and/or		
	accuchecks.				Designee will be responsible for		
	accucification.				ensuring that the documentation		
	D	ula a di Olivia a a			required for insulin administrat	ion	
	Review of a "B				is documented upon the		
	Monitoring Too	ol" for August, 2012, for			Medication Administration Rec		
	Resident #1, i	ndicated the			as referenced within our policy		
	accuchecks we	ere done and Novolog			and procedure and Indiana sta	ite	
		s ordered but did not			regulation R349 410 IAC		
	1				16.2-5-8.1(a)(1-4) Clinical		
	_	ave Resident #1 the			Records. How will the		
	insulin.				corrective action(s) will be		
					monitored to ensure the		
	Review of an A	August 2012			deficient practice will not rec	ur,	
	Medication Ad	ministration Record for			i.e., what quality assurance	• 2	
	Resident #1 in	dicated "See			program will be put into place. The Wellness Director and/or	er	
		xt to the sliding scale			Designee will perform weekly		
					audits of the Medication		
	insulin columns. It did not indicate who administered the sliding scale insulin. During an interview with the Wellness Director on 10/23/12 at 2:50 p.m. he				Administration Record to ensu	re	
					continued compliance for a pe		
					of six months. Findings will be		
					reviewed through the Worthing		
					House QA process after 6 six	,	
					months to determine the need	for	
		•			an ongoing monitoring plan.		
		urses should have			Findings suggestive of		
	_	tials when they gave			compliance will result in cessa	tion	
	the insulin.,				of the monitoring plan. Cessat	ion	
					of the monitoring plan will be		
	A facility policy	, dated 6/2008, titled			based upon results of random		
		edures for Providing for			reviews that indicate no addition		
		_			areas of concern concerning the	ne	
		tion of Subcutaneous			above referenced regulatory		
	Insulin) Injectio	on," received from the			criteria. The Regional Director	of	

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 20 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING	00 	COMPLETED 10/25/2012
	ROVIDER OR SUPPLIER NGTON HOUSE	10799 /	ADDRESS, CITY, STATE, ZIP CODE ALLIANCE DR 7, IN 46113	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE COMPLETION DATE
TAG	Regional Consultant Nurse on 10/23/12 at 3:05 p.m. indicated "8. Record the time and site (if so instructed) by initialing on the medication/treatment record on the appropriate day"	TAG	Quality and Care Managem and/or Designee will also per quarterly random on site revort the Medication Administrate Records to ensure continue compliance. By what date with the systemic changes be completed? 12/15/12	ent erform views ation d

State Form Event ID: 6H9D11 Facility ID: 003984 If continuation sheet Page 21 of 21